Northern Rockies Orthopaedics

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AUTHORIZATION FOR ACCESS/USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize the access, use, or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the release information may no longer be protected by federal privacy regulations and further charges may apply. The original medical record is property of Northern Rockies Orthopaedics.

Medical records or imaging sent or taken from another facility cannot be released.

Patient name: (Last, First, Other/Alias)	DOB:	SSN or MRN:

Please allow 3 business days for your request to be processed.

Medical record copy fees are determined by both the nature/purpose of your request and the format/method of delivery.

Montana Code Annotated 50-16-540 allows a reasonable fee for providing health care information may not exceed$0.50 cents for each page for a paper copy or photocopy. A reasonable fee may include an administrative fee that may not exceed $15 for searching and handling recorded health care information. There is a $15 charge for disc images.

Specific Date(s): _____to _____

Please check all that apply or describe the information specifically:

□ Office visit notes □ Financial Records □ CD of images ($15.00)
□ Operative Reports □ Physical Therapy

□ Other: _____ **Total Collected:** _____

I request my protected health information (PHI) to be released to the following person or organization:
□ Self (Patient) □ Third party

Facility /location: _____ Physician: _____
Address: _____
Fax #: _____

Delivery Method:
☐Mail
☐Fax
☐Pick Up
☐Email *(unavailable for imaging)*: _____

I have read the above and authorize the disclosure of the protected health information as stated.
This authorization will expire 12 months after the date of signature. I may revoke this authorization at any time by notifying the organization in writing.

Signature of Patient/Patient Representative	Date:
Print Name of Patient/Patient Representative	*Relationship or scope of your legal authority to act on the patient's behalf: